45th 9/25/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445108	A. BUILDING _____ B. WING _____	08/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, MURFREESBORO	420 N UNIVERSITY ST MURFREESBORO, TN 37130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An onsite visit was conducted during the annual recertification survey on August 9, 2010, thru August 11, 2010, at NHC Murfreesboro to investigate c/o #26217, 24872, 24197, 26082, and 26151. no deficiencies were cited related to the complaints.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to assess for self-administration of medications for one (#8) of thirty-three residents reviewed. The findings included: Resident #8 was admitted to the facility on July 21, 1998, with diagnoses including Closed Head Injury, Seizures, Persistent Vegetative State, and Organic Brain Syndrome. Medical record review of the Minimum Data Set dated May 7, 2010, revealed the resident was comatose and dependent for all activities of daily living. Medical record review of the June 2010, physician's recapitulation orders, signed by the physician on July 14, 2010, revealed the resident was to receive Atrovent (bronchodilator) unit dose	F 176	F 176 Resident # 8 was assessed for self administration on the nebulizer medication on 8/18/10. All patients receiving nebulizer medications will be assessed for self administration by 8/27/10. In-services were conducted by the DON for the Licensed Nurses on 8/16/10, 8/17/10, 8/23/10, and 8/31/10 regarding self administration of nebulizers and observation of patients receiving nebulizers. The DON or her designee will conduct a quality assurance study regarding nebulizer medication administration monthly for 3 months and then continue at the discretion of the Quality Assurance Committee.	8/31/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lynn B. Foster	Administrator	8/27/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 176	Continued From page 1 and Xopenex (bronchodilator) 0.63 mg by a nebulizer treatment. Medical record review revealed no documentation the resident had been assessed for self-administration of medications. Observation on August 9, 2010, at 3:05 p.m., revealed the resident sitting in an electric wheelchair, unattended, receiving a nebulizer treatment. Continued observation revealed the bottom of the nebulizer mask was located in the resident's mouth. Observation and interview on August 9, 2010, at 3:10 p.m., with Licensed Practical Nurse (LPN) #2, revealed the resident sitting in the electric wheelchair, with the bottom of the nebulizer mask located in the resident's mouth. Interview with LPN #2, at the time of the observation, revealed the nebulizer mask had been placed on the resident approximately 30 minutes prior to the observation. Continued interview with LPN #2 confirmed the resident had not been assessed for self-administration of medications.	F 176		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by:	F 246		

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F 246	Continued From page 2 Based on observation, and interview, the facility failed to provide insure a call light was within reach for one (#31) of thirty-three residents revlewed. The findings included: Resident #31 was admitted to the facility on August 2, 2008, with diagnoses including Dementia, History of Deep Vein Thrombosis, Contractures, Hypertension, and Chronic Pain. Review of the Minimum Data Set (MDS) dated July 1, 2010, revealed the resident had difficulty with long and short term memory, moderate difficulty with decision making skills, and required assistance with all activities of daily living. Observation on August 11, 2010, at 9:10 a.m., revealed the resident lying in the bed, and requesting a bed pan. Continued observation at the same time, revealed the call light had been placed on the bed side table out of the resident's reach. Interview with Certified Nursing Assistant (CNA #5) on August 11, 2010, at 9:10 a.m., in the resident's room, confirmed the resident needed to use the bed pan and the call light was not in the resident's reach.	F 246	F246 The call light for resident #31 was put into the patient's reach upon notification to the staff that it was not accessible to the patient. All patients at that time were checked for accessible call lights. In-services were conducted for nursing partners on 8/16/10, 8/17/10, 8/23/10 and 8/31/10. A quality assurance study will be conducted by the DON or her designee monthly until 100% compliance is met and then as directed by the Quality Assurance Committee.	8/31/10
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281		

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F 281	Continued From page 3 by: Based on medical record review, observation, and interview, the facility failed to follow the physician's orders for one (#12) of thirty-three residents reviewed. The findings included: Resident #12 was admitted to the facility on August 11, 2009, with diagnoses including Iron Deficiency Anemia, Congestive Heart Failure, Atrial Fibrillation, Chronic Kidney Disease, Diabetes with Neurological Manifestations, Peripheral Neuropathy, Anxiety, Depression, and Insomnia. Medical record review of a physician's order dated July 7, 2010, revealed the resident was to receive Procrit (medication to treat anemia) 40,000 units subcutaneously every three weeks, and to hold or not administer the medication if the hemoglobin was greater than 12 or the hematocrit was greater than 32. Medical record review of a physician's order dated July 19, 2010, revealed the hemoglobin and hematocrit were to be checked every month. Medical record review of a laboratory report dated July 6, 2010, revealed the hemoglobin was 9.3 (reference range 11.5-15.5) and the hematocrit was 27.9 (reference range 36.0-45.0). Medical record review of the July 2010, Medication Record revealed the Procrit was administered on July 8, 2010, and a box on the Medication Record indicated the Procrit was also to be administered on July 29, 2010. Continued review of the July 2010, Medication Record revealed the Procrit was not initialed as	F 281	**F281** The MD was notified of the missed Procrit on resident # 12 on 8/9/10 and the medication was discontinued per the physicians order. An review of all July MAR's was conducted by the unit managers on 8/10/10 to check for omitted medications. In-services regarding missed medications were conducted for Licensed Nurses by the DON on 8/10/10, 8/16/10, 8/17/10, 8/23/10, and 8/31/10. A quality assurance study regarding missed medications will be conducted monthly for 3 months and then as directed by the Quality Assurance Committee.	8/31/10

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F 281	Continued From page 4 administered on July 29, 2010. Observation on August 9, 2010, at 1:30 p.m., revealed the resident lying on a low bed, with bilateral floor mats in place. Interview on August 9, 2010, at 2:35 p.m., with Licensed Practical Nurse (LPN) #1, (nurse responsible for the administration of the Procrit on July 29, 2010), in the nursing station, confirmed the Procrit was not administered as ordered on July 29, 2010.	F 281		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's instructions, and interview, the facility failed to maintain the dietary department in a clean and sanitary manner. The findings included: Observation of the dietary department on August 9, 2010, at 9:30 a.m., with the Dietary Manager and the Registered Dietitian (RD), revealed the dishwasher failed to reach temperatures	F 371	F371 NHC Murfreesboro does maintain the dietary department in a clean and sanitary manner. The dish machine was inspected by Ecolab on 8/26/10. A new machine wash temperature thermostat and a heating element were installed. Thermostats and gauges were calibrated. Machine tested at a minimum of 162 degrees during wash cycle. Machine is working properly above minimum 160 degree wash temperature. Continuous monitoring will be maintained to ensure proper wash temperatures. All pans of various sizes were checked for wet nesting and pulled from shelves and re-washed immediately. Another drying shelf was purchased and delivered on 8/20/10. The two compartment sink table was cleaned and all debris removed around the table legs, and along the front edge of the lower shelf. The rest of the kitchen was inspected for cleanliness on 8/9/10. Staff was in-serviced on proper cleaning of shelf and signing off on cleaning list. The steam table in the front tray line was checked for proper temperature range. The pork chops and hamburger patties were re-heated and then served to the patients. In-services were conducted on 8/10/10 to dietary	

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F 371	Continued From page 5 recommended by the manufacturer, of 160 degrees F. during the wash cycle. Continued observation revealed the wash temperature reached 155 degrees F. Continued observation on August 9, 2010, at 10:35 a.m., revealed the dishwasher temperature reached 150 degrees F. Observation of the metal plate on the side of the dishwasher indicated the wash temperature should reach 160 degrees F. Continued observation on August 9, 2010, at 9:45 a.m., with the Dietary Manager and the R.D., revealed twenty-seven pans, of various sizes, were stacked and stored wet. Continued observation on August 9, 2010, at 9:50 a.m., revealed an eight foot, two compartment sink table had food, moisture, and debris built up around the table legs, and along the front edge of the lower shelf. Interview with the Registered Dietitian and Dietary Manager on August 9, 2010, at 10:40 a.m., in the kitchen, confirmed the dishwasher, hot temps, did not reach the manufacturer's recommendations; twenty-seven pans were stacked and stored wet, and the table had food, moisture, and debris built up on the second (lower) shelf. Observation of the hot food temperatures on August 10, 2010, at 11:50 a.m., with the Dietary Manager and the Registered Dietitian, of the front tray line, revealed the temperatures of the Pork Chops and Hamburger Patties were below the recommended hot food temperatures of 140 degrees F. or above. Continued observation of the Front Tray Line, revealed the Pork chops were 130 degrees F. and the Hamburger Patties were 120 degrees F. Both the Pork Chops and	F 371		

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F 371	Continued From page 6 the Hamburger Patties were pulled and reheated. Interview with the Registered Dietitian on August 10, 2010, at 12:15 p.m., in the dietary department, confirmed the food temperatures were below 140 degrees F. Interview with the RD on August 11, 2010, at 9:00 a.m., in the dietary department, confirmed approximately 5 - 7 trays were served prior to rechecking the food temperatures.	F 371	**F371** **cont.** staff on the cleaning schedule, proper procedures for storage of drying pans and monitoring of food items found below standard. The Dietitian will conduct a QA study on wet nesting, sanitation and food temperatures 3 x week for 1 month, monthly x 2 months, then as directed by the Quality Assurance Committee.	8/26/10
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and observation, the facility failed to ensure a medication was	F 425	**F425** Resident # 12 received her eye drops starting on 7/13/10 to current. A review of all MAR's was conducted to check for missed medications secondary to not being available from the pharmacy. A meeting with the pharmacy was conducted on 8/19/10 on procedures for medications not available. In-services for licensed nurses were conducted by the DON regarding medications not available on 8/16/10, 8/17/10, 8/23/10 and 8/31/10. A quality assurance study will be conducted to check for medication availability monthly for 3 months and then as directed by the Quality Assurance Committee.	8/31/10

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F 425	Continued From page 7 available for one (#12) of thirty-three residents reviewed. The findings included: Resident #12 was admitted to the facility on August 11, 2009, with diagnoses including Iron Deficiency Anemia, Congestive Heart Failure, Atrial Fibrillation, Chronic Kidney Disease, Diabetes with Neurological Manifestations, Peripheral Neuropathy, Anxiety, Depression, and Insomnia. Medical record review of the July 2010, physician's recapitulation orders revealed the resident was to receive Patanol (medication to treat allergic conjunctivitis) 0.1% ophthalmic solution one drop to each eye twice a day. Medical record review of the July 2010, Medication Record revealed the Patanol was circled as not administered on July 12, 13, and 14, 2010. Medical record review of the reverse side of the July 2010, Medication Record revealed on July 13, 2010, "Patanol gtts (drops) not available-ordered from pharmacy." Interview on August 10, 2010, at 7:10 a.m., with Licensed Practical Nurse (LPN) #3 (nurse responsible for the administration of the Patanol on July 12, 13, and 14, 2010), at the nursing station, confirmed the Patanol was not available on July 12, 13, and 14, 2010.	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		

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F 441	Continued From page 8 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility staff failed to wash the hands after providing incontinence care for one (#1) of	F 441	F441 The CNA that did not wash her hands after removing her gloves received education on proper hand washing on 8/11/10. In-services regarding proper hand hygiene were conducted by the DON for CNA's and Licensed nurses on 8/16/10, 8/17/10, 8/23/10 and 8/31/10. A quality assurance study will be conducted by the DON or her designee regarding observation of proper hand hygiene monthly for 3 months and then as directed by the Quality Assurance Committee.	8/31/10

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F 441	Continued From page 9 thirty-three residents reviewed. The findings included: Observation on August 11, 2010, at 10:20 a.m., revealed Certified Nursing Assistant (CNA) #1 providing incontinence care to resident #1, after an episode of fecal incontinence. Continued observation revealed after providing incontinence care to the resident, CNA #1 removed the gloves and without washing the hands, obtained clean linen from a linen cart located in the hallway. Continued observation revealed CNA #1 returned to the resident's room and placed the clean linen on the resident's bed. Continued observation revealed CNA #1 again exited the resident's room without washing the hands and opened the door to a linen closet, to obtain a pillow. Continued observation revealed there were no pillows located in the linen closet and CNA #1 proceeded to the elevator and pushed the button to go to the laundry to obtain a pillow. Review of the facility's policy Handwashing revealed "...Hands must be washed with soap and water when...Before and after assisting resident with meals or toileting..." Interview on August 11, 2010, at 10:35 a.m., with the Director of Nursing, in the nursing station, confirmed the hands are to be washed after providing incontinence care, and confirmed proper hand hygiene was not completed.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514		

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F 514	Continued From page 10 standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a complete medical record for one (#12) of thirty-three residents reviewed. The findings included: Medical record review of resident #12's July 2010, physician's recapitulation orders revealed the resident was to receive Patanol (medication to treat allergic conjunctivitis) 0.1% ophthalmic solution one drop to each eye twice a day. Medical record review of the July 2010, Medication Record revealed the Patanol was circled as not administered on July 12, and 14, 2010. Medical record review of the Nurses's Medication Notes, located on the reverse side of the July 2010, Medication Record revealed no documentation why the Patanol was not administered on July 12 and 14, 2010. Interview on August 9, 2010, at 2:50 p.m., with the Director of Nursing (DON), in the conference room, revealed when a medication was circled as	F 514	F514 Resident # 12's MD was notified regarding the eye drops. Resident # 12 received her eye drops starting on 7/13/10 to current. A review of July medication administration records to ensure proper documentation of medications that have been circled on the medication administration record. An in-service was conducted by the DON for licensed nurses on 8/16/10, 8/17/10, 8/23/10 and 8/31/10 regarding proper documentation of held medications. A quality assurance study will be conducted by the DON or her designee monthly for 3 months and then at the discretion of the Quality Assurance Committee.	8/31/10

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NHC HEALTHCARE, MURFREESBORO	420 N UNIVERSITY ST MURFREESBORO, TN 37130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 11 not administered, the reason for not administering the medication was to be documented on the reverse side of the Medication Record. Interview on August 10, 2010, at 7:10 a.m., with Licensed Practical Nurse (LPN) #3 (nurse responsible for the administration of the Patanol on July 12, and 14, 2010), at the nursing station, confirmed the reason for not administering the Patanol was not documented on July 12, and 14, 2010.	F 514		